GEORGIA DEPARTMENT OF COMMUNITY HEALTH

2014 Home Health Survey

Part A : General Information

1. Identification

UID:HHA030

Facility Name: Georgia Home Health Services, Valdosta

County: Lowndes

Street Address: 3404 Greystone Way

City: Valdosta

Zip: 31605-1048

Mailing Address: 3404 Greystone Way

Mailing City: Valdosta

Mailing Zip: 31605-1048

Medicaid Provider?
Check the box to the right if the agency is a medicaid provider ☑
If you indicated yes above, please report the medicaid number below.
00335057A

Medicare Provider?
Check the box to the right if the agency is a medicare provider ☑
If you indicated yes above, please report the medicare number below.
117058

2. Report Period

Report Data for the full twelve month period, January 1,2014 - December 31, 2014 (365 days).
Do not use a different report period.

Check the box to the right if your facility was **not** operational for the entire year. ☐
If your facility was **not** operational for the entire year, provide the dates the facility was operational.

Part B : Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey.

Contact Name: Lisa Scott

Contact Title: Business Office Manager

Phone: 423-531-2910

Fax: 423-886-4028

E-mail: lscott@triviumhealthcare.com

Part C : Ownership, Operation and Management

1. Ownership, Operation and Management

As of the last day of the report period, indicate the operation/management status of the facility and provide the effective date. Using the drop-down menus, select the organization type. If the category is not applicable, the form requires you only to enter Not Applicable in the legal name field. You must enter something for each category.

A. Agency Owner

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
GHHS Healthcare, LLC	For Profit	09/01/2011

B. Owner's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

C. Agency Operator

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

D. Operator's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

E. Management Contractor

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

F. Management's Parent Organization

Full Legal Name (Or Not Applicable)	Organization Type	Effective Date
Not Applicable		

2. Branch Offices

If your agency has a branch office or branch offices please check the box to the right. ☐

3. Branch Office Locations

If your agency operates branch offices please provide the following information on branch locations.

Branch Office	Street Address	Street City	County	Date Est.
Nashville	111 South Davis Street	Nashville	Berrien	09/01/2011

Tifton	1017 North Central Ave	Tifton	Tift	09/01/2011

Part D : Agency Utilization and Patient Caseload Information

1. Health-Related Visits

Please report the number of health-related visits (not units) during the report period by service/discipline. Also, please provide the per visit rate your agency charges for providing each of the services indicated. Use the blank lines to report other services/disciplines.

Service/Discipline	Number of Visits	Charge per Visit
Skilled Nursing	44,501	160
Physical Therapy	9,688	165
Home Health Aide	6,130	85
Occupational Therapy	3,170	165
Medical Social Services	1,103	185
Speech Pathology	2,151	165
	0	0
	0	0
	0	0

2. Agency Caseload

Please report the total number of cases at the end of the business day on December 31,2014.

634

4. Completed Medicare Episodes of Care

Provide the total number of completed Medicare episodes of care during the report year. Include all completed episodes including Low Utilization Payment Adjustments (LUPA).

3755

5. Health-Related Patients by Race/Ethnicity

Please report the number of health-related patients during the report period using the following race and ethnicity categories.

Race/Ethnicity	Number of Patients
American Indian/Alaska Native	2
Asian	4
Black/African American	762
Hispanic/Latino	18
Pacific Islander/Hawaiian	2
White	1,363
Multi-Racial	1

6. Health-Related Patients by Gender

Report the number of health-related patients by gender served during the report period.

Gender	Number of Patients
Male	807
Female	1,345

7. Health-Related Visits by Payer

Please report the number of Health-Related visits, unduplicated patients, and the gross and net

patient revenue during the report period by each payer. Please note that gross and net patient revenue totals must balance to those reported in Part E.)

Payer	Patients	Visits	Gross Revenue	Net Revenue
Medicare	1,324	40,738	6,503,980	6,503,980
Medicaid	178	2,830	418,854	420,676
Other Government Payers	40	645	20,009	16,250
Managed Care (HMO/PPO)	598	18,737	2,838,476	2,484,317
Other Third Party Insurers	39	630	15,275	13,221
Self Pay	53	53	9,514	9,514
Other Non Government	224	3,110	121,233	101,015

Part E : Agency Financial Summary, Indigent and Charity Care Provided and Patient Point of Origin

1.Indigent and/or Charity Care Policy

Check the box to the right if the agency had a formal written policy or written policies concerning the provision of indigent and/or charity care during 2014. ☑

If you indicated yes above, please indicate the effective date of the policy or policies.

09/01/2011

2. Person Responsible

Please indicate the name and title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.

Lori McGuire Adminstrator

3. Charity Care Provision

Check the box if the policy or policies included provision for the care that is defined as charity. ☑

4. Financial Table

Please complete the following financial table for the 2014 calendar year. Please note that Total Uncompensated Indigent and Charity Care Charges (automatically calculated by the database) should not exceed Gross Indigent and Charity Care Charges.

Revenue or Expense	Amount
Gross Patient Revenue	9,927,341
Medicare Contractual Adjustments	139,497
Medicaid & Peachcare Contractual Adjustments	0
Other Contractual Adjustments	40,182
Total Contractual Adjustments	**179,679**
Bad Debt	98,176
Indigent Care Gross Charges	79,933
Indigent Care Compensation	0
Uncompensated Indigent Care (Net)	**79,933**
Charity Care Gross Charges	20,580
Charity Care Compensation	0
Uncompensated Charity Care (Net)	**20,580**
Other Free Care	0
Total Net Patient Revenue	**9,548,973**
Adjusted Gross Patient Revenue	**9,689,668**
Other Revenue	0
Total Net Revenue	**9,548,973**
Total Expenses	6,773,809
Adjusted Gross Revenue	**9,689,668**
Total Uncompensated I/C Care	**100,513**
Percent Uncompensated Indigent/Charity Care	**1.04%**

5. Indigent or Charity Care Cases

Report the number of home health care patients who were classified as being indigent or charity care cases and for which patient charges were written off to indigent or charity care accounts as reproted in Part E, Question 4 above.

30

6. Patient Point of Origin

Report the number of home health care patients who were referred to your agency by each of the following healthcare points of origin

Point of Origin	Number of Patients Referred
Hospitals (via discharge planner)	1,035
Physicians	1,022
Other Home Health Agencies	15
All Other Healthcare Providers	242

7. Referral Hospitals

Please provide the names of the hospitals above who referred patients during the report year.

Hospital Name	Patients Referred
Archilbold Memorial Hospital	14
Brook County Hospital	7
Childrens Healthcare of Atlanta	1
Colquitt Regional Medical Center	2
Dorminy Medical Center	20
Emory University Hospital	12
Medical Center Of Central Georgia	5
Phoebe Putney Hospital	24
Memorial Hospital of Adel	1
Saint Joseph's Hospital	1
Shanda Gainesville	7
Smith Northview	58
Tallahasee Memorial Hospital	6
Regional Medical Center	294
South Georgia Medical Center	471
Northside Hospital	1
Irwin Coutny Hospital	14
Jack Hughston Memorial Hospital	5
Select Specialty Hospital	9
Coffee Regional Medical Center	7
Baptist Medical Center	1
Childrens Medical Center	1
Columbus Regional Hughston Hospital	8
Dotcots Hosptial of Augusta	1
Mayo Clinic Jacksonville Florida	6
Medical Center Navient Health	1

Optim Medical Center	3
Pearlman Cancer Center	3
Phoebe Worth Medical Center	1
Shands Jacksonville Medical Center	1
Veterans Administrator Gainesville	50
Total	**1,035**

Part F : Agency Workforce Information

This information is being collected to support Georgia's healthcare workforce planning activities.

1. Budgeted FTE

Please report the number of budgeted fulltime equivalents (FTEs) and the number of vacancies as of 12-31-2014.

Profession	Budgeted FTEs	Vacant Budgeted FTEs	Contract/Temporary Staff FTEs
Registered Nurses (RNs Advanced Practice)	23	2	0
Licensed Practical Nurses (LPNs)	18	1	0
Aides/Assistants	4	0	0
Allied Health/Therapists	15	1	0

2. Filling Vacancies

Please enter the average time needed during the past six months to fill each type of vacant position.

Type of Vacancy	Average Time Needed to Fill Vacancies
Registered Nurse	10 days
Licensed Practical Nurse	20 days
Aide/Assistant	20 days
Allied Health/Therapists	30 days

Part G : Monthly Admissions, Readmissions and Utilization by Patient County

1. Monthly Admissions and Readmissions

Provide the number of new admissions and readmissions in each of the months during the report year

Month	New Admissions	Re-Admissions
January	187	0
February	179	4
March	161	3
April	150	9
May	183	14
June	175	9
July	187	24
August	177	17
September	178	27
October	193	34
November	188	31
December	198	30

2A. Patient Origin Part A.

Patient Origin - Report the admissions, visits, and caseload by county for the report period. Caseload totals are for 1/1/2014. Admissions should capture all admissions during the report year. Visits should capture all visits during the report year. Report patients served for the four age cohort groups. The Total Patients column will be automatically calculated. You will not be able to enter data in that column. Also provide patients for ages 60 to 79 in the column provided.

County	Beginning Caseload	Admissions	Total Visits	Patients 60-79	I/C Patients	Patients Under 18	Patients 18-64	Patients 65-79	Patients 80 & Over	Total by Age
Ben Hill	41	149	5,222	129	1	2	57	66	9	134
Berrien	67	302	8,175	277	5	2	99	256	30	387
Brooks	27	98	2,488	76	0	0	28	97	2	127
Cook	23	67	1,569	56	2	4	26	51	4	85
Echols	4	10	206	13	0	0	5	7	3	15
Irwin	21	56	2,877	46	11	0	15	53	20	88
Lanier	13	97	2,628	90	1	5	41	41	12	99
Lowndes	240	915	26,663	764	14	8	10	528	61	607
Tift	76	333	11,464	324	5	5	5	406	22	438

Turner	52	129	5,436	22	2	0	51	105	16	172
Total by Age	**0**	**0**	**0**	**0**	**0**	**26**	**337**	**1,610**	**179**	**2,152**

2B. Patient Origin Part B.

Please report the Gross Charges, Adjusted Gross Patient Revenue and Net Uncompensated Charges by County. The grand total of each of these must balance to the Gross Patient Revenue, Adjusted Gross Patient Revenue and Net Uncompensated Charges reported in Part E Question 4.

County	Gross Charges	Adjusted Gross Patient Revenue	Net Uncompensated Charges
Ben Hill	721,375	715,350	6,025
Berrien	1,259,684	1,252,459	7,225
Brooks	424,424	419,890	4,534
Cook	203,844	198,420	5,424
Echols	40,536	35,411	5,125
Irwin	459,120	454,346	4,774
Lanier	387,593	381,481	6,112
Lowndes	3,901,159	3,726,832	37,167
Tift	1,742,589	1,721,036	21,553
Turner	787,017	784,443	2,574
Total	**9,927,341**	**9,689,668**	**100,513**

Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or incaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I further understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature: James T Poteet

Date: 03/24/2015

Title: President

Comments: